MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00583

108

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH:

County: Garrett

City or town: Loch Lynn, Maryland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 month

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: Loch Lynn, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Stanley Merle Biser.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 23d, 1946.

8. AGE:

Years	Months	Days	If less than one day
0	1	16	hrs. min.

9. Birthplace: Loch Lynn, Maryland. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Marshell D. Biser.

13. Birthplace: Oakland, Maryland.

MOTHER — 14. Maiden name: Mamie Hosford.

15. Birthplace: Leakesville, Miss.

16. Informant: Marshell D. Biser.

Address: Loch Lynn, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof January 11/47 (month) (day) (year)

Cemetery or crematory: Maple Springs Cemetery.

Location: Eglon, W. Va.

18. Funeral director: Emery D. Baldeu

Address: Oakland. Md.

19. Jan. 9 1947 Julia A. Rowan (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 9th 1947 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Jan 46 to 9 Jan 47

and that I last saw him alive on 9 Jan 47

Immediate cause of death: Lobar Pneumonia. — DURATION: 3 days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Eudene E. Nuzum MD M. D. or other

Address: Oakland Md Date signed: 10 Jan 47

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-35

00584

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

CERTIFICATE OF DEATH

★ Reg. Dist. No. 1620

1. PLACE OF DEATH:
County GARRETT
City or town (RURAL) SALISBURY-PA-RD#1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County GARRETT
City or town (RURAL) SALISBURY-PA RD#1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war NO

3.(a) FULL NAME MR-CHARLES-W-BITTINGER

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	widowed

6.(b) Name of husband or wife Mary Howell deceased 6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) October 12 - 1870

8. AGE: Years	Months	Days	If less than one day
76	3	9	— hrs. — min.

9. Birthplace GARRETT-CO-MARYLAND (Town, county, and state)
10. Usual occupation COAL-MINER (Retired)
11. Industry or business COAL-MINING
FATHER 12. Name JACOB-BITTINGER
13. Birthplace GARRETT-CO-MARYLAND
MOTHER 14. Maiden name ELLEN-FACENBAKER
15. Birthplace GARRETT-CO. MARYLAND
16. Informant Frank Bittinger
Address Salisbury R.D. 3
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof Jan. 23-1947 (month) (day) (year)
Cemetery or crematory Newton Bittinger Cemetery
Location Near Bittinger, Md. Garrett Co. Md
18. Funeral director Stanley M. Thomas
Address Salisbury, Penna.
19. Jan 22 1947 (Date rec'd by registrar) Ethel Broadwater Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1947, at 1:A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 2 1944, to Jan. 1947
and that I last saw him alive on Jan. 14 1947

Immediate cause of death	DURATION
Influenza, bronchial	1 wk.
33a	
Due to	
Due to	
Other conditions Non-rheumatic myocardial degeneration, secondary anemia	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Grant Attwell M. D. or other
Address Meyersdale, Pennsylvania Date signed 1-21-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

~~Sol~~ '96 ★ 005856 Reg. Dist. No. 166

1. PLACE OF DEATH:
County Garrett
City or town Oakland, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County Garrett
City or town Oakland, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Harry Willison Davis.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Bertha Perrin Davis. Deceased. 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 21st, 1867.

8. AGE: Years	Months	Days	If less than one day
79	5	23	..... hrs. ..... min.

9. Birthplace Oakland, Maryland. (Town, county, and state)
10. Usual occupation Retired Hotel Manager.
11. Industry or business

FATHER
12. Name Henry Davis.
13. Birthplace Allegheny County,

MOTHER
14. Maiden name Maria E. Willison.
15. Birthplace Allegheny County.

16. Informant Donald Davis.
Address Oakland, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 15/47 (month) (day) (year)
Cemetery or crematory Oakland, Cemetery.
Location Oakland, Maryland.
18. Funeral director Emroy D. Baldwin
Address Oakland, Md.
19. Jan 15. 1947 (Date rec'd by registrar) Julia A. Rowan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13th, 1947, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 10 1946 to Jan 12 1947
and that I last saw h.. alive on Jan 12 1947

Immediate cause of death	DURATION
Emaciation.	
Due to Malnourishment, Malnutrition	
bad living conditions -	
Due to	
Other conditions Dissecting Aneurism abdominal aorta sec. to arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. A. Gannon Jr. M.D.
M. D. or other
Address Oakland Md. Date signed Jan 14 '47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55b 00586

CERTIFICATE OF DEATH

Reg. Dist. No. 1660

1. PLACE OF DEATH:
County: Garrett
City or town: Crellin, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland, County: Garret
City or town: Crellin, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: John William DeWitt.

3. (b) Social Security Number: 218-03-0487

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Viola Ashby DeWitt.
6.(c) If alive, give age: 49 years
7. Birth date of deceased (mo., day, yr.): April 22d, 1897.

8. AGE: Years	Months	Days	If less than one day
49	8	16	hrs. min.

9. Birthplace: Swallow Falls, Maryland. (Town, county, and state)
10. Usual occupation: Coal Operator.
11. Industry or business

FATHER
12. Name: Lucian DeWitt.
13. Birthplace: Garrett County, Md.

MOTHER
14. Maiden name: Catherine E. Sanders.
15. Birthplace: Garrett County, Md.

16. Informant: Mrs. Viola DeWitt.
Address: Crellin, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof January 19/47 (month) (day) (year)
Cemetery or crematory: Gortner Cemetery.
Location: Gortner, Maryland.
18. Funeral director: Emory D. Bolden
Address: Oakland, Md.
19. Jan 19 19 47 (Date rec'd by registrar) Julia A. Rowan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 17th, 1947 at 2:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28 1946 to Jan. 17 1947 and that I last saw him alive on Jan 17. 1947

Immediate cause of death	DURATION
Carcinoma: Metastatic of Lung;	
Due to Carcinoma Rt. hip joint	
Due to	
Diher condiiions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Emerson S. Thomas M.D. M. D. or other
Address: Oakland Md Date signed: 18 Jan 47

VS-A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00587

92d

CERTIFICATE OF DEATH

Reg. Dist. No. 1620

1. PLACE OF DEATH:

County: Garrett

City or town: RD Grantsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 79 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: RD Grantsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Goddard Doerr

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Etta Doerr

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): June.3,1864

8. AGE:

Years	Months	Days	If less than one day
82	7	26	....hrs. ....min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Farming

11. Industry or business: None

FATHER

12. Name: Yost Doerr

13. Birthplace: Germany

MOTHER

14. Maiden name: Not Known

15. Birthplace: Not Known

16. Informant: Harry Doerr

Address: RD Grantsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 31, 1947 (month) (day) (year)

Cemetery or crematory: Grantsville

Location: Grantsville, Maryland

18. Funeral director: Wm Winterberg

Address: Grantsville, Md.

19. Jan 30 1947 (Date rec'd by registrar) Ethel Broadwater Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 29, 1947, at 1:A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1946, to Jan 29 1947

and that I last saw him alive on Jan 1 3 1947

Immediate cause of death	DURATION
Chronic Valvular Heart Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. R. Davis M.D. M. D. or other

Address: Grantsville Md. Date signed Jan 29 47

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

56b

Reg. Diat. No. 00588 1620

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Garrette
City or town: Friendsville R D
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Eliza Friend

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 27 1865

8. AGE: Years	Months	Days	If less than one day
81	7	6	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own home

FATHER
12. Name: William Umbel
13. Birthplace: Maryland

MOTHER
14. Maiden name: Harriet Savage
15. Birthplace: Maryland

16. Informant: Troy Friend
Address: Uniontown Pa,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/5/47 (month) (day) (year)
Cemetery or crematory: Blooming Rose Cem-
Location:
18. Funeral director: E. E. Harned
Address: Brandonville, W.Va,

19. Jan 4 19 47 Kathryn Fike. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 3 19 47, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov - 19 46, to Jan - 3 - 19 47
and that I last saw h...e.r alive on December - 27 - 19 46

Immediate cause of death	DURATION
Senility & 162b	
Complete exhaustion	2 Mos
Due to	
Due to Uterine Fibroma 56b	4 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: N. B. Messenger M.D.
M. D. or Other
Address: Addison - Pa Date signed 1/4/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1566 ★ 00589

CERTIFICATE OF DEATH

Reg. Dist. No. 161

1. PLACE OF DEATH:

County: Garrett

City or town: Selbysport Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 50 yrs 0 mos

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Garrett

City or town: Selbysport Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Phoebe Ellen Friend

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) ~~Single, married~~, widowed, or ~~divorced~~
F	W	

6.(b) Name of husband or wife: deceased

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 8 1853

8. AGE:

Years	Months	Days	If less than one day
93	6	6	hrs. min.

9. Birthplace: Pa (Town, county, and state)

10. Usual occupation: Home Wife

11. Industry or business:

FATHER 12. Name: John Lowe Shoop

13. Birthplace: Pa

MOTHER 14. Maiden name: Trout

15. Birthplace: Pa

16. Informant: Mrs. Friend

Address: Selbysport Md

17. (Burial, cremation, or removal: Which?) Date thereof: Jan 26-47 (month) (day) (year)

Cemetery or crematory: Friendsville

Location: Friendsville Md

19. Funeral director: H.H. Swanger

Address: Friendsville Md

19. Jan 25 1947 (Date rec'd by registrar) Kathryn Fike. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24 1947 at 9 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945, to Jan 24 1947

and that I last saw her alive on Now 1946

Immediate cause of death	DURATION
Exhaustion	—
Due to: Senility Muscular Atrophy	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: N.B. Messenger MD
M. D. or other

Address: Addison Pa Date signed: Jan 25/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00590

Reg. Dist. No. 166

1. PLACE OF DEATH:
County Garrett
City or town Gorman
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 weeks
Hospital, institution, or street address where death occurred: ----
How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County Garrett
City or town Deer Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5 Mi. South
(If rural, give LOCATION)
2.(a) If veteran, name war ----

3.(a) FULL NAME
Clara Huggerth Holland

3.(b) Social Security Number ----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Clifton E. Holland
6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) July 9, 1901

8. AGE: Years	Months	Days	If less than one day
45	5	26	.....hrs. .....min.

9. Birthplace Concordia, Kansas.
(Town, county, and state)
10. Usual occupation House Wife
11. Indusfry or business Own Home

FATHER
12. Name John A. Huggerth
13. Birthplace Sweeden

MOTHER
14. Maiden name Emily C. Nelson
15. Birthplace Sweeden

16. Informant Edith Johnson
Address Concordia, Kansas.

17. Burial Date thereof Jan. 6, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Oak Grove Cemetery
Location 2 mi. north Gorman, Md.
18. Funeral director Herbert C. Leighton
Address Oakland, Md.

19. Jan. 6 19 47 Julia A. Roman
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4, 1947 3:05 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 Jan 19 47 to 4 Jan 19 47 and that I last saw h.. alive on 3 Jan 47 19..

Immediate cause of death	DURATION
Acute Nephritis	
Due to Myocarditis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE C. E. Manes, M.D.
M. D. or other
Address Oakland Md. Date signed 1/5/47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a 4

00591

CERTIFICATE OF DEATH

Reg. Dist. No. 1771

1. PLACE OF DEATH:
County: Garrett
City or town: Mt. Lake Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Kiser Nursing Home
How long in hospital or institution? 5mon.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Rural- Vindex
(If outside city or town limits, write RURAL and give nearest town)
Street No. Johnstown Coal & coke Co . Mines
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: James Robert McCloud

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 24, 1873

8. AGE: Years	Months	Days	If less than one day
73	8	1	..... hrs. ..... min.

9. Birthplace: Barre, Maine
(Town, county, and state)

10. Usual occupation: miner

11. Industry or business: Coal Mines

FATHER — 12. Name: Unknown
13. Birthplace: "

MOTHER — 14. Maiden name: "
15. Birthplace: "

16. Informant: Records at Johnstown C.&.C. Co.,
Address: Vindex, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 28, 1947 (month) (day) (year)

Cemetery or crematory: Kalbaugh Cemetery
Location: Elk Garden, Mineral Co., W.Va.

18. Funeral director: Otha F. Sharpless
Address: Blaine, W.Va.

19. Jan 28 1947 (Date rec'd by registrar) A.W. Bassett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 25 1947, at P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-28-46 to 1-2-47
1m 1-25-47 No 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Acute Heart attack 30 minutes	
Was Paralized from cerebral hemorrhage	
Due to Arteriosclerosis	6 months dont know how long
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Thos. F. Bowers M. D. or other
Address: Oakland, Maryland Date signed 1-27-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

2-25

2-1720 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00592

38 b

Reg. Dist. No. 1660

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Held to 9th Grant Family Healthy

1. PLACE OF DEATH:
County Garrett
City or town Mt. Lake Park,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred:
Kiser Nursing Home
How long in hospital or institution? 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Garrett
City or town Rural Swanton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3 Mi. N W Swanton
(If rural, give LOCATION)
2.(a) If veteran, name war ----

3.(a) FULL NAME
Henry Archibold Miller

3.(b) Social Security Number
----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Nevada Miller
6.(c) If alive, give age ---- years

7. Birth date of deceased (mo., day, yr.) March 17, 1869

8. AGE:	Years	Months	Days	If less than one day
	77	9	27	....hrs. ....min.

9. Birthplace Sharon, Pa. (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Own Farm
FATHER 12. Name Thomas Miller
13. Birthplace Scottland
MOTHER 14. Maiden name Jessie Archibold
15. Birthplace Scottland
16. Informant Mrs. Herbert Biggs
Address Western port, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 15, 1947 (month) (day) (year)
Cemetery or crematory Thayerville Cemetery
Location Garrett Co., Md.
18. Funeral director Herbert C. Leighton
Address Oakland, Md.
19. Jan. 15, 1947 (Date rec'd by registrar) Julia A. Rowe Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13, 1947 at 1:05P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-2-46 to 1-13-47
and that I last saw him alive on 1-13-47
Immediate cause of death Heart attack — DURATION 2 days
Due to Influenza — 2 wWeel
Due to ----
Other conditions Was paralized about 12 years ago frmo mine accident
(Include pregnancy within 3 months of death)

Major findings of operations ----
Date of op. ----
Autopsy results ----
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ---- Date of ----
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ----
Means of injury ---- Injured at work?

23. SIGNATURE [signature] M. D. or Other
Address 1-13-47 Oakland, Md. Date signed 1-13-47

2-35

Evidence for the change of year of age birth is shown on G 108 1/23/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

Reg. Dist. No. 04593b

1. PLACE OF DEATH:
County: Garrett
City or town: Swanton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Swanton, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Mary O'Brien.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife: John T. O'Brien
6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): October 14th 1872

8. AGE: Years	Months	Days	If less than one day
74 ~~75~~	2	28	....hrs. ....min.

9. Birthplace: Bittinger, Md. (Town, county, and state)
10. Usual occupation: House Wife.
11. Industry or business

FATHER
12. Name: Joseph Brenneman
13. Birthplace: Bittinger, Maryland.

MOTHER
14. Maiden name: Catherine Bittinger.
15. Birthplace: Bittinger, Maryland.

16. Informant: Howard J. O'Brien.
Address: Swanton, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 14 1947 (month) (day) (year)
Cemetery or crematory: Bittinger Cemetery.
Location: Bittinger, Maryland.

18. Funeral director: Emroy D. Boldue
Address: Oakland, Md.

19. Jan. 14 1947 (Date rec'd by registrar) Julia A. Rowen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 11th, 1947, at 12:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 6 1947 to Jan 11 1947 and that I last saw h... alive on Jan 10 1947

Immediate cause of death	DURATION
Stomatitis ulcerativa	
Due to Inability to swallow	
food & Flaccid Paralysis.	
Due to Cerebral Hemorrage, Hypertension.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. A. Gannon Jr MD M. D., or other
Address: Oakland Md. Date signed: Jan 13 '47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

00594

CERTIFICATE OF DEATH

Reg. Dist. No. 17-1

1. PLACE OF DEATH

County Garrett

City or town Kitzmiller

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett

City or town Kitzmiller

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Albert Paugh

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Eliza Ellen (Tasker) Paugh

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): April 5, 1869

8. AGE: Years	Months	Days	If less than one day
77	9	15	...hrs. ...min.

9. Birthplace: Bethel, Garrett Co., Md. (Town, county, and state)

10. Usual occupation: Miner & Merchant

11. Industry or business: retiredminer- Grocer

FATHER — 12. Name: Joseph Paugh

FATHER — 13. Birthplace: Garrett Co., Md.

MOTHER — 14. Maiden name: Margaret McVicker

MOTHER — 15. Birthplace: Cresaptown, Alleg. Co., Md.

16. Informant: Lester Paugh

Address: Cresaptown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 23 1947 (month) (day) (year)

Cemetery or crematory: Paugh Cemetery

Location: near Barnum, Garrett Co., Md.

18. Funeral director: Otha F. Sharpless

Address: Blaine, W.Va.

19 Jan 23 19 47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 20 19 47 at 8:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 19 47 to Jan 20 19 47 and that I last saw h.s. alive on Jan 20 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to Auricular Fibrillation	
Due to Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE Ralph Calandella M.D. or other

Address Kitzmiller, Md Date signed Jan 21-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

2-25

2-1721 — 2-10

343=6

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

00595

CERTIFICATE OF DEATH

Reg. Dist. No. 1660

1. PLACE OF DEATH:
County: Garrett
City or town: Swallow Falls, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett.
City or town: Swallow Falls, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: William Arthur Ream.

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower.

6.(b) Name of husband or wife: Elsie Sines Ream.
Deceased 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 23d, 1862

8. AGE: Years	Months	Days	If less than one day
84	6	27	hrs. min.

9. Birthplace: Oakland, Maryland.
(Town, county, and state)
10. Usual occupation: Retired Farmer.
11. Industry or business

FATHER
12. Name: Eli Ream.
13. Birthplace: Lancaster, Pa.

MOTHER
14. Maiden name: Mary E. Friend.
15. Birthplace: Garrett County.

16. Informant: Bert C. Ream.
Address: Oakland, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 22d/47. (month) (day) (year)
Cemetery or crematory: Taylor Sines Cemetery.
Location: Swallow Falls, Md.

18. Funeral director: Ernest D. Bolden
Address: Oakland, Md.

19. Jan 22 1947 (Date rec'd by registrar) Julia A. Rowan Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 19th 1947 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 11, 1947, to Jan. 19 1947, and that I last saw h alive on 19

Immediate cause of death	DURATION
Broncho pneumonia.	
Due to Hypertrophy of prostate	
Due to Cystitis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Andrew E. Thayer M.D. M. D. or other
Address: Oakland, Md. Date signed: 20 Jan 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

2-3

HVS-20010—150M—10-42

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

93d

Primary Dist. No. .....

File No. .....

Registered No. PC 10596

CERTIFICATE OF DEATH

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact Statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Garrett
(b) Township .....
(c) Borough Friendsville M. D.
(d) City .....
(e) Name of hospital or institution .....
(If not in hospital or inst. write street number or location)
(f) Length of stay: In hospital or inst. — (g) In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Garrett
(c) City or town Friendsville
(If outside city or town limits, write RURAL)
(d) Street No. — (If rural give location)
(e) If citizen of foreign country, name country —

3. (a) FULL NAME ANNA C. ROHRBACHER

3. (b) If U. S. Veteran, complete reverse side of certificate

3. (c) Social Security No. —

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Calvin A. Rohrbacher

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased Oct. (Month) 28 (Day) 1892 (Year)

8. AGE: Years	Months	Days	If less than one day
54	2	19	hr. ..... min.

9. Birthplace West Newton (City, town, or county) Pa. (State or foreign country)

10. Usual occupation Housewife

11. Industry or business —

MOTHER/FATHER

12. Name John O. Lindabarger

13. Birthplace Pennsylvania (City, town, or county) (State or foreign country)

14. Maiden name Martha Baker

15. Birthplace Pennsylvania (City, town, or county) (State or foreign country)

16. (a) Informant's own signature .....
(b) Address .....

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. (Month) 20 (Day) 1947 (Year)
(c) Place West Newton County Westmoreland State Pa.

18. (a) Signature of funeral director J. H. McCauley
(b) Address West Newton

19. (a) Jan 17, 1947 (Date received local registrar) (b) Kathryn Fike (Registrar's signature)

MEDICAL CERTIFICATION

20. Date of death: Month JANUARY 16th, day 16th, year 1947, hour 9, minute 20 PM

21. I hereby certify that I attended the deceased from May 10th, 1946, to JAN 16th, 1947, that I last saw h.er alive on JAN 16th, 1947 and that deatb occurred on the date and hour stated above.

	DURATION
Immediate cause of death: Cerebral hemorrhage	14 DAYS
Due to: hypertention	12 YRS
Due to:	
Other conditions: Chronic Myocarditis (Include pregnancy within 3 months of death)	

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations none
Of autopsy none

22. If death was due to external causes, fill in the following:
(a) (Probably) Accident, suicide, or homicide (specify) .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature Milton Jeffes, (M. D. ~~or other~~)
Address FRIENDSVille, Md. Date signed Jan 17, 1947

Did the deceased have Military or Naval service during any war in which the armed forces of the United States were engaged? YES or NO..... If such service was rendered, furnish the following information:

Branch of service. ARMY.....NAVY.....MARINE CORPS.....NURSE CORPS.....

Name of War.....Serial Number on discharge.....

Organization and rank at discharge.....

.....

Enlisted.....Discharged.....

Serial Number on adjusted compensation certificate.....

Character of Discharge.....Wounded in action? YES or NO.....

Number of months overseas.....

1-35

Evidence for the addition of usual residence of deceased is shown on G 108 1/13/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13/a

00597

CERTIFICATE OF DEATH

Reg. Dist. No. 1610

1. PLACE OF DEATH:
County: Garrette
City or town: Friendsville R D
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Friendsville - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Sariah A Savage

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: C M Savage
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Nov 11 1880

8. AGE: Years	Months	Days	If less than one day
66	I	22	hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own home

FATHER:
12. Name: Jeremiah Fletcher
13. Birthplace: Normalville Pa.

MOTHER:
14. Maiden name: Jermiah Grimm
15. Birthplace: Maryland

16. Informant: lamoore
Address: Friendsville R.D

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/6/47 (month) (day) (year)
Cemetery or crematory: Thomas Cem-
Location: Markleysburg Pa,
18. Funeral director: E G Harned
Address: Brandonville, W.Va,

19. Jan 4 1947 (Date rec'd by registrar) Kathryn Fike. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 3 1947, at 7P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan-3- 1947 to Jan-3- 1947 and that I last saw h.. alive on Jan-3- 1947

Immediate cause of death	DURATION
Anemic Coma	?
Due to	
Due to Chr. Interstital Nephritis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: N. B. Mearmore M.D.
M. D. or other
Address: Addison Pa Date signed 1/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46b

10598

Reg. Dist. No. 161

1. PLACE OF DEATH:
County: Garrett
City or town: Friendsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All his life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Garrett
City or town: Friendsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME Benjamin F. Schmeyer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Nancy E. Schmeyer
6.(c) If alive, give age: 67 years
7. Birth date of deceased (mo., day, yr.): Oct 16-1873

8. AGE: Years: 73 | Months: 3 | Days: 5 | If less than one day: hrs. min.

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Retired Merchant
11. Industry or business:
FATHER 12. Name: Jacob Schmeyer
13. Birthplace: Md
MOTHER 14. Maiden name: Bitner
15. Birthplace: Md
16. Informant: Cecil Schmeyer
Address: Friendsville Md
17. (Burial, cremation, or removal. Which?) Date thereof: Jan. 23-47 (month) (day) (year)
Cemetery or crematory: Friendsville
Location: Near Presbyterian church
18. Funeral director: W. W. Lemmon
Address: Friendsville Md
19. Jan 23 1947 (Date rec'd by registrar) Kathryn Tike Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JANUARY 21 1947, at 9:15 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 19 1947, to January 21 1947
and that I last saw h alive on 19

Immediate cause of death	DURATION
Hemorrhage from stomach	2 days
Due to Carcinoma of stomach	1 Year
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no operation
Date of op.
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: no Date of
Where did injury occur? no injury (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Milton Jeffers MD M. D. or other
Address: Friendsville Md Date signed January 22, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

01034

Reg. Dist. No. 166

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:
County: Garrett
City or town: Deer Park Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mos.
Hospital, institution, or street address where death occurred: Church Street.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Vindex, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Minervia Ellen Sims

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife: George Sims
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September, 23, 1871

8. AGE: Years	Months	Days	If less than one day
75	4	5	..... hrs. ..... min.

9. Birthplace: Hartmonsville, Mineral Co. W.VA.
(Town, county, and state)
10. Usual occupation: Domestic- at home
11. Industry or business

FATHER
12. Name: Andrew Aronhalt
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Eliza Evans
15. Birthplace: West Virginia

16. Informant: Mrs. Howard Knox
Address: Vindex, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb, 1, 1947 (month) (day) (year)
Cemetery or crematory: Tasker Cemetery
Location: Vindex, Maryland.

18. Funeral director: Ellsworth S. Boal
Address: Westernport, Maryland.

19. Feb. 1, 1947 (Date rec'd by registrar) Julia I Rawson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January-28- 1947, 19..., at 11-20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Several Years, 19..., to ..., 19...
and that I last saw h... alive on January-26- 1947, 19...

Immediate cause of death	DURATION
Cerebral Hemorrhage	1-Wk
and paralysis, arterio sclerosis	5-yrs.
Due to: Chronic Nephritis of long standing	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Edward E Sellers M.D.
M. D. or other
Address: Deer Park Md. Date signed: Feb 1-1947

2-35

00599

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

73a

Reg. Dist. No. 166

1. PLACE OF DEATH:
County Garrett
City or town Oakland, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 69 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Garrett
City or town Oakland, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Benjamin Hinkle Sincell.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife Lillian Morris Sincell
6.(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) July 11th, 1869

8. AGE: Years	Months	Days	If less than one day
77	6	0	....hrs. ....min.

9. Birthplace Frederick, Maryland.
(Town, county, and state)
10. Usual occupation Publisher.
11. Industry or business

FATHER
12. Name Charles H. Sincell.
13. Birthplace Frederick County, Md.

MOTHER
14. Maiden name Leah Richardson.
15. Birthplace Frederick County, Md.

16. Informant Donald R. Sincell.
Address Oakland, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 13/47 (month) (day) (year)
Cemetery or crematory Oakland Cemetery.
Location Oakland, Maryland.

18. Funeral director Emmay D. Bolden
Address Oakland, Md.

19. Jan 14 1947 (Date rec'd by registrar) Julia A. Rowen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11th 1947, at 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 11 1946, to 11 Jan 1947 and that I last saw him alive on 10 Jan 1947

Immediate cause of death	DURATION
Pernicious Anemia.	4-6 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Andrew E. Mann M.D. M. D. or other
Address Oakland Md Date signed 1/2 Jan 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

2-35

00600

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

CERTIFICATE OF DEATH

★1 Reg. Dist. No. 1660

1. PLACE OF DEATH:
County Garrett
City or town Oakland, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Garrett
City or town Oakland, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Israel Thompson Spiker.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife Etta DeWitt Spiker.
6.(c) If alive, give age 80 years
7. Birth date of deceased (mo., day, yr.) May 7th, 1855

8. AGE: Years	Months	Days	If less than one day
91	8	7	hrs. min.

9. Birthplace Garrett County, Md.
(Town, county, and state)
10. Usual occupation Retired Farmer.
11. Industry or business
FATHER 12. Name Jacob Spiker.
13. Birthplace Unknown
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown
16. Informant Mrs. Raymond Sines.
Address Oakland, Mafyland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 17th/47 (month) (day) (year)
Cemetery or crematory Gray Cemetery.
Location Near Oakland, Maryland.
18. Funeral director Emory D. Boldey
Address Oakland, Md.
19. Jan 17 19 47 Julia T. Rowan Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14th, 1947, 12:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Examined after to Dead 19
and that I last saw h alive on 19
Immediate cause of death Cerebral Arteriosclerosis

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. L. Baumgartner M.D. Examining Physician
Duty Med.
M. D. or other
Address Oakland Md Date signed 1/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

2-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00601

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 171 0

1. PLACE OF DEATH:
County: Garett
City or town: Rural Near Bittinger
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Garett
City or town: Rural Near Bittinger
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Thomas Stanton

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Catherine Stanton
6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): May II-1872

8. AGE: Years	Months	Days	If less than one day
74	8	4	hrs. min.

9. Birthplace: Rural Near Bittinger (Town, county, and state)

10. Usual occupation:

11. Industry or business: Farmer

FATHER — 12. Name: Thomas Stanton
13. Birthplace: Near Bittinger Md

MOTHER — 14. Maiden name: Louise Broadwater
15. Birthplace: R.D.2 Grantsville Md

18. Informant: Mrs Catherine Stanton
Address: Bittinger Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: I-17-1947 (month) (day) (year)
Cemetery or crematory: Bittinger
Location: Bittinger Md

18. Funeral director: Wm. Winebrenner
Address: Grantsville Md

19. Jan 16 1947 (Date rec'd by registrar) J. E. Emory Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 15 1947 at 6.30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1947, to Jan 14 1947
and that I last saw him alive on Jan 10 1947

Immediate cause of death	DURATION
b. Chronic Myocarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. R. Davis M.D. M. D. or other
Address: Grantsville Md Date signed: Jan 15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

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